STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. BUILDING 01 B. WING _____	01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON MANOR	1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/05/11 Facility Number: 000241 Provider Number: 155636 AIM Number: 100291310 Surveyor: Mark Caraher, Life Safety Code Specialist At this survey, Wellington Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas not separated from the corridor. The facility has a capacity of 112 and had a census of 88 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on APPROVED 2/1/11 RB ~~The facility~~ was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:	K 000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Post Survey Review on or after February 4, 2011. RECEIVED JAN 26 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 1/26/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025 SS=E	Continued From page 1 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 7 of 7 openings through the ceiling into the attic in the Sprinkler Riser Mechanical room and the Boiler room by the laundry were maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect any resident, staff or visitor in the vicinity of the Sprinkler Riser Mechanical room and the Boiler room by the laundry. Findings include: Based on observation with the Maintenance Director during the tour of the facility from 11:15 a.m. to 1:50 p.m. on 01/05/11, the Sprinkler Riser Mechanical room ceiling has four openings which are not firestopped. One opening measured twelve inches long by one inch wide. Two openings were in the annular space around two inch diameter water pipes and measured four inches in diameter. One opening was in the annular space around a twelve inch diameter	K 025	**K025 Smoke Barriers** It is the practice of this provider to ensure that all alleged violations involving smoke barriers being constructed to provide at least a one half hour fire resistance rating are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** 7 of 7 openings through the ceiling into the attic in the Sprinkler Riser Mechanical room and the Boiler room by the laundry have been repaired using firestopped material. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. All identified areas have been repaired with firestopped material.	

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Maintenance Director, or his designee, will inspect for open areas that do not have firestopped material as required during routine preventative maintenance rounds. Any areas found not in compliance will be repaired.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?

Results of routine rounds will be reviewed by the monthly safety committee meeting.

CQI Committee will review results monthly for 3 months and quarterly thereafter to maintain compliance.

Date of Compliance
2/4/2011

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K 025	Continued From page 2 exhaust duct and measured fourteen inches in diameter. Based on interview at the time of observation, the Maintenance Director stated an earlier water leak caused damage to the ceiling which is now in the process of being repaired but is not yet firestopped. Based on observation with the Maintenance Director during the tour of the facility from 11:15 a.m. to 1:50 p.m. on 01/05/11, the Boiler room by the laundry room had two openings in the ceiling each measuring two inches in diameter and a third opening in the ceiling measuring four inches long by one inch wide. Based on interview at the time of observation, the Maintenance Director acknowledged the three openings in the Boiler room ceiling are not firestopped.	K 025		
K 038 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 10 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as electromagnetic locks to unlock upon actuation of	K 038	**K038 Exit Access** It is the practice of this provider to ensure that exit access is arranged so that exits are readily available at all times in accordance with State and Federal law through established procedures. **What corrective action(s) will be taken for those residents found to have been affected by the alleged deficient practice?** On January 17 Contractor replaced relay and gate keypad. **How will you identify other residents having the**	

potential to be affected by the same alleged deficient practice, and what corrective action will be taken.

All residents needing to utilize the gate exit have the potential to be affected by this alleged deficient practice.

On January 17 Contractor replaced relay and gate keypad.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

During times of fire alarm activation the electromagnetic lock will be tested by the Maintenance Director, or his designee, to ensure proper operation.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?

Results of fire alarm testing and proper operation of

electromagnetic locks will
be reviewed at monthly
Safety Committee meeting.

CQI Committee will review
testing results monthly for
3
Months and quarterly
thereafter.

Date of Compliance
1/17/11

6/12

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K 038	Continued From page 3 an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires that all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice could affect any resident, staff and visitor exiting from the courtyard. Findings include: Based on observation with the Maintenance Director during the tour of the facility from 11:15 a.m. to 1:50 p.m. on 01/05/11, the courtyard fence gate is equipped with an electromagnetic lock which did not unlock upon activation of the fire alarm at 1:09 p.m. Based on interview at the time of observation, the Maintenance Director acknowledged the courtyard fence gate should have unlocked upon activation of the fire alarm system. 3.1-19(b)	K 038	**K045 Illumination of Means of Egress** It is the practice of this provider to ensure that all alleged violations involving illumination of means of egress are provided in accordance with State and Federal law through established procedures. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Light fixtures with double bulbs were installed at the 5 of 9 exit means of egress. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken?**	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 045	All residents have the potential to be affected by this alleged deficient practice. Light fixtures with double bulbs were installed at the five of 9 exit means of egress. **What measures will be put into place or what systemic**	

changes will you make to ensure deficient practice does not recur?

During routine preventative maintenance rounds Maintenance Director, or his designee, will inspect for proper illumination of exits.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?

Safety Committee will review results of preventative maintenance rounds monthly.

CQI Committee will review results of preventative maintenance monthly for 3 months and quarterly thereafter.

2/4/11 q.w.

8/12

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K 045	Continued From page 4 failed to ensure the lighting for 5 of 9 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect any of the residents as well as staff, and visitors needing to exit the facility from the Harmony Hall, Serenity Hall, Kitchen, West Hall and East Hall exits. Findings include: Based on observation with the Maintenance Director during the tour of the facility from 11:15 a.m. to 1:50 p.m. on 01/05/11, the exit means of egress outside the Harmony Hall, Serenity Hall, Kitchen, West Hall and East Hall exits are each equipped with one light fixture with only one bulb. Based on interview at the time of observation, the Maintenance Director acknowledged only one light fixture with one bulb was provided at each of these exits. 3.1-19(b)	K 045	**K062 Required automatic sprinkler systems to be maintained in reliable operating condition and inspected and tested periodically.** It is the practice of this provider to ensure that all alleged violations involving automatic sprinkler systems being maintained in operating condition and inspected and tested periodically are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the alleged deficient practice?**	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested annually. NFPA 25, 1998 Edition, the Standard for the	K 062	On January 18, 2011 Contractor completed Hydrant Flow Test on (2) Hydrants. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** All residents have the potential to be affected by	

this alleged deficient practice.

On January 18, 2011 contractor completed Hydrant Flow Test on (2) Hydrants.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

Maintenance director to place on preventative maintenance calendar to schedule an annual Hydrant Flow Test with Contractor.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?

Preventative maintenance schedule to be reviewed monthly by Safety Committee.

Preventative maintenance schedule to be reviewed by the CQI Committee monthly for 3 months and quarterly thereafter.

Date of Compliance 1/18/11.

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K 062	Continued From page 5 Inspection, Testing, and Maintenance of Water Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on observation and interview with the Maintenance Director during the tour of the facility from 11:15 a.m. to 1:50 p.m. on 01/05/11, the facility lacked documentation to show the two private fire hydrants on the facility's property had an annual inspection during the past year. 3.1-19(b)	K 062	**K143 Transferring of Oxygen** It is the practice of this provider to ensure that all alleged violations involving the transferring of oxygen are provided in accordance with State and Federal law through established procedures. **What corrective action(s) will be taken for those found to have been affected by the alleged deficient practice?** Mechanical ventilation was installed in room.	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2	K 143	**How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. Mechanical ventilation was installed in room. **What measure will be put into place or what systemic changes will you**	

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K 143	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where oxygen transferring takes place was provided with continuous mechanical ventilation. This deficient practice could affect any resident, staff or visitor in the vicinity of the West Hall oxygen storage and transfilling room. Finding include: Based on observation with the Maintenance Director during the tour of the facility from 11:15 a.m. to 1:50 p.m. on 01/05/11, the West Hall oxygen storage and transfilling room which is used to store six liquid oxygen canisters was not provided with continuous mechanical ventilation. Based on interview at the time of observation, the Maintenance Director acknowledged the West Hall oxygen storage and transfilling room was not provided with continuous mechanical ventilation. 3.1-19(b)	K 143	**make to ensure that the deficient practice does not recur?** Inspection for proper working order of mechanical ventilation system will be made by Maintenance Director, or his designee, during routine preventative maintenance rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Results of routine maintenance rounds will be reviewed by the monthly safety committee. CQI Committee will review results monthly for 3 months and quarterly thereafter. Date of Compliance 2/4/11	